Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909
517-335-0918
Fax 517-373-2179
www.michigan.gov/healthlicense

Board Use Only

DATA CHANGE/DUPLICATE LICENSE REQUEST

Authority: Public Act 368 of 1978, as amended.

PHARMACY STORES AND MANUFACTURER/WHOLESALER/DISTRIBUTORS DO NOT USE THIS FORM FOR A NAME OR ADDRESS CHANGE. YOU WILL NEED TO COMPLETE A RELOCATION APPLICATION WHICH CAN BE OBTAINED EITHER ONLINE AT WWW.MICHIGAN.GOV/HEALTHLICENSE OR BY CONTACTING THIS OFFICE.

NURSE AIDES DO NOT USE THIS FORM. YOU NEED TO CONTACT THOMSON PROMETRIC (FORMERLY THE CHAUNCEY GROUP) AT 1-800-748-0252 TO OBTAIN THE PROPER FORM FOR NAME AND/OR ADDRESS CHANGE.

Address changes can also be processed on-line by visiting our website at www.michigan.gov/mylicense. However, please use this form when requesting a name change.

Type or Print Only

Current Name on License/Registration: _____
Last First Middle

Profession: _____

MI Permanent I.D. Number: _____

U. S. Social Security Number	Date of Birth	Phone Number

Please check the boxes below for the service you are requesting:

Please specify which licenses/registrations you want changed. **NO CHANGES WILL BE MADE IF THIS FORM IS NOT COMPLETE.**

☐ Professional License/Registration ☐ Controlled Substance ☐ Specialty License ☐ Drug Control

☐ 1. **NAME CHANGE**: I request the Department to change my records due to a name change. A **copy** of the legal document **(i.e. marriage certificate, divorce decree or other form of legal documentation)** must be submitted, with this form, to verify the name change you are requesting. Your signature must be provided on reverse side. If you would like a new license reflecting your new name, please see fee requirement on reverse side.

New Name: _____
(Print Clearly) Last First Middle

Reason for Change: _____

☐ 2. **ADDRESS CHANGE FOR PROFESSIONAL AND/OR SPECIALTY:** I request the Department to change my record due to an address change. Your signature must be provided on reverse side. If you would like a new license reflecting your new address, please see fee requirement on reverse side.

Name of Office/Facility:
(If applicable) _____

Address: _____

City, State and Zip Code: _____

Phone Number w/Area Code: _____

Name:

☐ 3. **ADDRESS CHANGE FOR CONTROLLED SUBSTANCE AND DRUG CONTROL LICENSE:** I request the Department to change my record due to an address change. Your signature must be provided below. If you would like a new license reflecting your new address, please see fee requirement listed below.

MI Permanent I.D. Number: _____

Name of Facility or Office: _____

Facility or Office Address: _____

City, State and Zip Code: _____

Phone Number w/Area Code: _____

☐ 4. **DUPLICATE LICENSE $10.00 for each license**: I request the Department to issue a duplicate for the following reason:

☐ Data Change ☐ Lost ☐ Stolen ☐ Not received ☐ Destroyed

Please check **below** the license(s) you are requesting a duplicate to be issued. Make your check payable to the State of Michigan for the total amount.

☐ Professional License/Registration - $10.00
☐ Controlled Substance - $10.00
☐ Specialty License - $10.00
☐ Drug Controlled - $10.00

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this request.. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

Signature:	Date: